

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1.
 - a. Whether there should be additional reimbursement for date of service, 05/23/01.
 - b. The request was received on 05/14/02. Additional information was received on 05/17/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60
 - b. UB-92
 - c. EOBs
 - d. Based on Commission Rule 133.307 (g) (4), the Division notified the Requestor of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/06/02. There is no response from the Requestor in the file. A "No Additional Information Received" from the Requestor is reflected in Exhibit I.
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

There is not a carrier sign sheet submitted with the dispute packet. The carrier did submit two responses to the dispute dated 06/11/02 and 06/24/02. Furthermore, the Commission notified the Requestor with a copy to the insurance carrier Austin Representative of the Requestor's requirement to submit two copies of additional documentation relevant to the fee dispute on 06/06/02.

III. PARTIES' POSITIONS

1. Requestor: No position statement.
2. Respondent: Letter dated 06/24/02:

"Provider billed Carrier \$9,693.04....Carrier reduced the bill to a fair and reasonable amount using denial code 'M' and reimbursed Provider \$1,300.00..." The carrier's methodology includes a schedule using reference points set in the Commission's per diem rates in the TWCC Acute Care Inpatient Hospital Fee Guideline, the Medicare payment rates for ambulatory surgical procedures, the payments rates established by the workers' compensation authorities in Nevada, Massachusetts, Pennsylvania, and Mississippi, and the recent decisions of the State Office of Administrative Hearing.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 05/23/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$9,693.04.
4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$1,300.00.
5. The amount in dispute is \$4,576.04.

V. RATIONALE

Medical Review Division's rationale:

The Requestor has submitted UB-92s for ambulatory surgical services for date of service 05/23/01. The bill in dispute is broken down into operating room services, iv therapy, supplies, recovery room charges, etc. However, the total is considered the facility fees (what the facility charged for providing the facility, equipment and supplies in order for the surgical procedure to be done).

The carrier has denied the charges in dispute as "F – Reduced According to Fee Guidelines" and "G – Global." The Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed.

When determining whether or not additional reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. After review of the dispute file, no documentation was noted to support the services billed. **No** reimbursement is recommended.

The above Findings and Decision are hereby issued this 16th day of August 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

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